CENTER FOR HEALTH INFORMATION AND ANALYSIS

Data Specification Manual

957 CMR 2.00: Payer Reporting of Relative Prices

March 17, 2014

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1. Introduction

M.G.L. c. 12C, § 8 requires the Center for Health Information and Analysis ("Center") to "publicly report relative prices, as newly defined in Section 1 as contractually negotiated amounts paid to providers by each private and public carrier for health care services, including non-claims related payments and expressed in the aggregate relative to the payer's network-wide average amount paid to providers."

Regulation 957 CMR 2.00 governs the methodology and filing requirements for health care payers to calculate and report this data to the Center. The Data Specification Manual provides additional technical details to assist payers in reporting and filing this data.

Payers are required to submit three Relative Price files to the Center annually. The files will contain hospital data for the previous calendar year, physician group data for the calendar year ending sixteen months prior, and other provider data for the previous calendar year. Files can only contain data for one year. Files will contain different record types, including
   a. Payer comments (in all files)
   b. Separate relative price data with distinct lines for Medicare Advantage; Medicaid; Commonwealth Care; commercial; Medicare and Medicaid Dual Eligibles, 65 and over; Medicare and Medicaid Dual Eligibles, 18-64; and Other by:
      - Acute hospital inpatient
      - Acute hospital outpatient
      - Psychiatric hospital inpatient, including behavioral health data for acute hospitals with psychiatric care or substance abuse units
      - Psychiatric hospital outpatient, including behavioral health data for acute hospitals with psychiatric care or substance abuse units
      - Chronic hospital inpatient
      - Chronic hospital outpatient
      - Rehabilitation hospital inpatient
      - Rehabilitation hospital outpatient
      - Physician group practices
      - Ambulatory surgical centers
      - Community health centers
      - Community mental health centers
      - Freestanding clinical labs
      - Freestanding diagnostic imaging
      - Home health agencies
      - Skilled nursing facilities

Please see Appendix D of this document for information regarding file naming conventions for hospital and non-hospital relative price data files, layout specifications, and field definitions.

2. File Submission Instructions & Schedule

Payers will submit flat files with relative price data via INET. INET registration forms and submission instructions are available on the Center's website. The flat file fields are variable length

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and relative to position; therefore, they need to be separated by an asterisk *. Payers must include every data element for each record type. All fields marked as required must have either a letter or a number in the field. If the payer does not have information for a required field, then the payer should mark a 'NA' or '0' into the field. If a field is not required, then the payer may leave the field space blank; however, the payer must still have the appropriate space for that field.

In 2014, payers will submit three relative price files to the Center. The 'HOS' notation will apply to hospital relative price files, the 'PG' notation will apply to the physician group relative price file and the 'OP' notation will apply to the other provider relative price file. If a file is notated as HOS, it must contain only hospital record types. If a file is notated as PG or OP, it must contain only non-hospital record types. Please note that the physician group and other provider file submissions contain the same record types. If the record types reported in the file do not match the required naming convention, the file will fail submission in INET. Please see the last page of this document for complete file naming instructions.

The header record (HD-RP) requires metadata information for the file and contains two fields for payer comments. The "RP Comments" field (HD012) allows payers to explain any variances or data issues that they wish to disclose to the Center while the "additional comments" field (HD013) allows payers additional space to provide explanatory information. For instance, if the payer's reimbursement method differs by insurance category, the payer must note the standard payment unit used for each insurance category in the header comments section (HD012 and HD013). The payment unit used must be uniform within each insurance category.

Payers will submit relative price information in accordance with regulation 957 CMR 2.00 on the following schedule:

Relative Prices Filing Schedule	
Date	**Files Due**
May 1, 2014	CY13 Hospital Relative Prices CY12 Physician Group Relative Prices CY13 Other Provider Relative Prices

Upon receipt of a payer's relative price data, payers will be able to access a summary report of their data on INET within 24 hours of successful submission. After reviewing this report, a payer's Chief Financial Officer or equivalent must sign and return the data verification statement on the final page of the summary report within ten days. A payer's filing is not complete until the data verification statement has been received by the Center.

3. Identification of Providers

Payers must report relative price data for all Massachusetts-based providers with which they contract. Payers should include claims data for non-Massachusetts members if they seek care at a Massachusetts provider. The Center has published a uniform provider list on the Center's website for the provider groups for which reporting is required. The link to the list may be found in

Appendix A. When submitting hospital, community health center, or skilled nursing facility data, payers are <u>required</u> to use the Org IDs listed on the Center's website.
For physician groups, payers are to report the top 30 physician groups based on total payments, according to their contractual relationships. Payers shall report all remaining physician group payments in aggregate under OrgID 999998 for aggregate physicians not paid on a fee schedule, or OrgID 999999 for aggregate physicians paid on a fee schedule.

For all other provider types, payers are to report providers that received more than 3% of a payer's total payments for that provider type. Payers must use the OrgIDs identified on the uniform provider list.

Payers must report aggregate data for other health care providers to which a payer paid less than 3% of total payments for that provider type. Please use the appropriate organization type OrgID as listed below when reporting aggregate data for Other Providers. The Center may request additional information on these providers.

Aggregate Organization Type	OrgID
Freestanding Ambulatory Surgical Centers	999901
Community Health Centers	999902
Community Mental Health Centers	999903
Freestanding Clinical Laboratories	999904
Freestanding Diagnostic Imaging Centers	999905
Home Health Agencies	999906
Skilled Nursing Facilities	999907

4. Payer Reporting Guidelines

Payers must report relative price data for the specified provider groups by insurance category (Medicare Advantage; Medicaid; Commonwealth Care; commercial insurance; Medicare and Medicaid Dual Eligibles, 65 and over; Medicare and Medicaid Dual Eligibles, 18-64; and Other) and by product type (HMO and POS, PPO, Indemnity, and other). The relative price data submission includes information regarding non-claims payments, provider-specific product mix, and provider-specific service mix.

Non-Claims Payments. Non-claims payments include all payments made pursuant to the payer's contract with a provider that were not made on the basis of a claim for medical services. Only payments made to providers are allowable. Payments to government entities, such as the Health Safety Net Surcharge, are not allowable.

Payers must report non-claims payments for each provider, service setting (hospital inpatient, hospital outpatient, and professional services) by insurance category and by product type. Non-claims payments may be "specified" or "non-specified." Specified payments are payments that are directly attributable to a provider, service setting, insurance category, and product type; for example, a performance bonus paid to a hospital for inpatient services for Medicare Advantage HMO plans. Non-specified payments are payments that are only attributable in part to a provider, service setting, insurance category and product type; for example, a performance bonus paid to a hospital, but not otherwise specified for a given product or patient population at that hospital. Payers must report the specified payment amounts

whenever this data is available. For the balance of non-specified payments, payers must allocate on the basis of percentage of claims payments. Non-claims payments made to hospital systems or provider groups as a whole must be allocated to each hospital (inpatient and outpatient individually) or physician local practice group according to the claims payments made to the entities as a percent of total claims payments. Please see the example in Appendix C for further detail.

In the relative price submission, payers will only report the final non-claims amount for each provider, insurance category, and product type combination. The Center may request additional detail regarding non-claims payment allocation.

Product Mix. Product mix is the percentage of total payments (claims and non-claims) to a provider attributed to each product type. Product mix is reported by provider for each insurance category. Product types are defined by the Center as HMO and POS, PPO, Indemnity, and Other. For example:

	HMO and POS	PPO	Indemnity	Other	Total
Total Payments	$52,000	$20,000	$17,000	$11,000	$100,000
Product Mix	**52%**	**20%**	**17%**	**11%**	**100%**

Service Mix. Service mix is the percentage of claims payments to a provider attributed to each service type. This is reported by provider for each product type and insurance category. Payers will define service types in record type SL. The service types should mirror or closely approximate the categories for which payers separately negotiate rates. Payers will report service multipliers for each service type. Categories must be consistent within a provider category.

For example, if a payer negotiates three distinct fee schedules with a hospital for emergency services, lab services, and radiology services, the service mix would be reported as follows:

	ED	Lab	Radiology	Total
Claims payments	$60,000	$20,000	$20,000	$100,000
Service Mix	**60%**	**20%**	**20%**	**100%**

If the payer does not negotiate different fee schedules by service type, then the payer should report one record for record type SL with a service mix of 100% reported (as 1.00) in the HOS record type.

a) **Hospital Inpatient**

Hospital inpatient data will be reported in a single record type but separately identified by hospital type (acute, psychiatric/substance abuse, chronic, rehabilitation). Payers must report hospital-specific base rates, total claims payments, case mix, total number of discharges, and total non-claims payments.

Payers must submit additional behavioral health-only relative price data for acute hospitals with psychiatric or substance abuse units. For such acute hospitals, the payer will report data for the same hospital twice: once with the acute hospital record type, submitting data for all services including behavioral health, and again with the psychiatric hospital record type, submitting behavioral health data only.

Hospital-Specific Base Rate. Payers are required to report the hospital-specific base rate in field IPR008. For payers using a DRG-based payment model, this rate is the negotiated rate per discharge, prior to applying any adjustments for case mix or severity of illness.

For acute hospitals that are not paid on a DRG model, the payer must calculate a hospital-specific base rate equivalent. The base rate equivalent can be derived by assigning DRG weights for claims and then dividing the actual payments by the sum of the DRG weights (also known as case mix adjusted discharges, or CMADs), as shown below. Payers who utilize the base rate equivalent model must report the number 2 in field IPR007.

Row	Content	Hospital 1	Hospital 2	Hospital 3	Hospital 4
1	Actual payments made to Hospital for a given insurance category and product type	$500,000	$900,000	$300,000	$1,000,000
2	Sum of the DRG weights for claims for a given insurance category and product type	120.22	171.25	107.52	137.5
3	Provider-Specific Base Rate for a given insurance category and product type (Row 1 /Row 2)	$4,159	$5,255	$2,790	$7,273

Payers who do not pay acute hospitals on a DRG basis and would experience significant hardship in obtaining the software needed to derive a DRG base rate equivalent may apply to the Center for a waiver from this requirement. Payers granted such a waiver must utilize a standard per unit rate for all acute hospitals. To seek a waiver, payers must submit a written account of the hardship imposed and a proposed alternative unit. Waivers will be granted only in instances in which a payer would undertake additional costs in obtaining needed software. Waivers will not be granted on the basis of increased difficulty in deriving base rate equivalents. Payers who are granted a waiver and utilize a uniform unit rate must report the number 3 in field IPR007.

For chronic, rehabilitation, or psychiatric hospitals, payers may use a standard per unit rate as long as a uniform unit is applied within each hospital type. If a non-DRG unit rate is used, payers must report the number 2 in field IPR007.

The Center will calculate the following fields based on the data submitted by the payer.

1. <u>Product-Specific Adjusted Base Rate</u>. The sum of total claims and non-claims payments divided by the product of case-mix index and discharges.

2. <u>Hospital Product Adjusted Base Rate</u>. The sum of the products of the adjusted base rate for each product type and the corresponding network average product weight.

3. <u>Hospital Inpatient Relative Price</u>. The hospital's product adjusted base rate divided by the network average hospital product adjusted rate within each insurance category.

b) **Hospital outpatient, physician group, and other provider**

For the hospital outpatient, physician group, and other provider record types, payers must submit provider-specific service multipliers (service categories to be determined by the payer), total claims-based payments, total non-claims payments, provider-specific service mix, and provider-specific product mix.

Provider-Specific Service Multipliers. Provider-specific service multipliers are the negotiated service-specific mark-up from the standard fee schedule, reported for each provider, by insurance category and product type. The service multipliers must be defined for each service type reported in record type SL. Payers must provide negotiated multipliers wherever feasible.

If the provider is not paid on a fee-for-service basis (e.g. percent of charge basis), the multiplier is the ratio of actual paid claims for a given service line to the network average payment for that service line. An example of this derivation is below.

Row	Content	Service 1	Service 2	Service 3	Service 4
1	Actual payments made to provider for a given insurance category and product type	$500,000	$750,000	$300,000	$1,000,000
2	Network average payment rate	$325,000	$300,000	$200,000	$550,000
3	Provider-Specific Service Multiplier (Row 1/Row 2)	1.54	2.50	1.50	1.82

When the service category includes only one CPT code, then the multiplier is derived as the Service Category 1 (ER) example. When the service category includes more than one CPT code, then the multiplier is derived as the Service Category 2 (Lab) example.

Service Category 1 (ER)					
	Provider A		**Provider B**		**Network Average**
Total Cost	100		1000		**183.3333333**
Units	1		5		(100+1000) / (1+5)
Multiplier	**0.5454545**		**1.0909091**		
	(100/1/183)		(1000/5/183)		

Service Category 2 (Lab)					
	Provider A		**Provider B**		**Network Average**
CPT code x					
Total Cost	250		700		**73.07692308**
Units	3		10		(250+700) / (3+10)
CPT code y					
Total Cost	300		700		**83.33333333**
Units	3		9		(300+700) / (3+9)
Multiplier	**1.1721311**		**0.9454545**		
	(250+300) / (3*73 + 3*83)		(700+700) / (10*73 + 9*83)		

Other Provider Service Mixes. Because network average service mixes are calculated by the Center, submitting a network average service mix is no longer a required part of the submission process. However, you can still submit a network average for validation and verification purposes. When calculating Network Average Service Mixes in the Other Provider file, network service mixes should total to 1 for each combination of Organization Types included in the Service Lookup table. For example, if there are 2 service lookups for Community Health Centers and 2 service lookups for Home Health Agencies, then the network average service mix for Community Health Centers should total to 1 and the network average service mix for Home Health Agencies should equal to 1. When reporting the network average service mix to the Center for Other Providers, please use the appropriate OrgID listed below.

Network Average Organization Type	OrgID
Freestanding Ambulatory Surgical Centers	999100
Community Health Centers	999200
Community Mental Health Centers	999300
Freestanding Clinical Laboratories	999400
Freestanding Diagnostic Imaging Centers	999500
Home Health Agencies	999600
Skilled Nursing Facilities	999700

The following fields will be calculated by the Center.

1. <u>Base Service Weighted Multiplier</u>. The sum of the products of each multiplier and its network-wide service mix weight for each product type.

2. <u>Base Service and Product Adjusted Multiplier</u>. The sum of the products of the base service weighted multipliers for each product and the corresponding network average product mix.

3. <u>Non-Claims Multiplier</u>. The total non-claims payments divided by the total claims payments for each product type, the result of which is multiplied by the base service weighted multiplier for the corresponding product type

4. <u>Product Adjusted Non-Claims Multiplier.</u> The sum of the products of the non-claims multiplier for each product type and the corresponding network average product weight.

5. <u>Adjusted Rate.</u> The sum of the base service and product adjusted multiplier and the product adjusted non-claims multiplier.

6. <u>Relative Price</u>. The provider specific adjusted rate divided by the network average adjusted rate.

Appendix A: Uniform Provider List

http://www.mass.gov/chia/researcher/hcf-data-resources/payer-data-reporting/total-medical-expenses-filing-information.html

Appendix B: Data Submission Examples

http://www.mass.gov/chia/researcher/hcf-data-resources/payer-data-reporting/total-medical-expenses-filing-information.html

Appendix C: Non-Claims Payment Allocation Methodology

Total Non-Claims Payments	$10,000,000		Total Claims Paid	Claims-Based Distribution	Specified Non-Claims Payment	Allocation of Claims for Non-Specified Non-Claims Payments	Non-Specified Non-Claims	Total Payments
Non-Claims Payments Specified for System X Hospital Inpatient	$6,000,000	System X Hospital Inpatient	$150,000,000	50%	$6,000,000	50%	$2,000,000	$158,000,000
Non-Claims Payments Specified for System X Hospital Outpatient	$ -	System X Hospital Outpatient	$125,000,000	42%		42%	$1,667,666	$126,666,667
Non-Claims Payments Specified for System X Professional Services	$ -	System X Professional Services	$25,000,000	8%		8%	$333,333	$25,333,333
Non-Specified Claims Payments to System X	$4,000,000							

Allocation of Non-Claims Payments by Insurance Category

Hospital Inpatient Insurance Category Allocation

Insurance Category	Total Claims Paid for Basis of Allocation	Allocation of Specified Non-Claims Payments	Specified Non-Claims Payment	Allocation of Non-Specified Non-Claims Payments (claims-based distribution)	Non-Specified Non-Claims Payments	Total Payments
Medicare	$57,000,000	33%	$1,980,000	38%	$750,000	$59,730,000
Medicaid	$22,500,000	25%	$1,500,000	15%	$300,000	$24,300,000
Commonwealth Care	$9,000,000	42%	$2,520,000	6%	$125,000	$11,645,000
Commercial	$61,500,000	0%	$0	41%	$825,000	$62,325,000
Total for all Insurance Categories with Specified Non-Claims Allocation			**$6,000,000**			
Total for all Insurance Categories with Non-Specified Non-Claims Allocation					**$2,000,000**	
Overall Total	**$150,000,000**		**$6,000,000**		**$2,000,000**	**$158,000,000**

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MEDICARE:

Allocation of Specified Non-Claims Payments

Hospital Inpatient Product Allocation

Product Type	Total Claims	Distribution of Specified Non-Claims Payments	Specified Non-Claims Payments
HMO and POS	$22,800,000	40%	$792,000
PPO	$19,950,000	35%	$693,000
Indemnity	$11,400,000	20%	$396,000
Other	$2,850,000	5%	$99,000
Total	**$57,000,000**		**$1,980,000**

Allocation of Non-Specified Non-Claims Payments

Hospital Inpatient Product Allocation

Product Type	Total Claims	Distribution	Allocation of Non-Specified Non-Claims Payments
HMO and POS	$22,800,000	40%	$300,000
PPO	$19,950,000	35%	$262,000
Indemnity	$11,400,000	20%	$150,000
Other	$2,850,000	5%	$38,000
Total	**$57,000,000**		**$750,000**

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Hospital Outpatient Product Allocation

Product Type	Total Claims	Distribution	Allocation of Non-Specified Non-Claims Payments
HMO and POS	$11,250,000	30%	$150,090
PPO	$15,000,000	40%	$200,120
Indemnity	$6,750,000	18%	$90,054
Other	$4,500,000	12%	$60,036
Total	**$37,500,000**		**$500,300**

Professional Services Product Allocation

Product Type	Total Claims	Distribution	Allocation of Non-Specified Non-Claims Payments
HMO and POS	$3,000,000	40%	$40,000
PPO	$2,250,000	30%	$30,000
Indemnity	$1,500,000	20%	$20,000
Other	$750,000	10%	$10,000
Total	**$7,500,000**		**$100,000**

Appendix D: Data Submission Guidelines

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
HD-RP	1	HD001	Header Record Identifier	01/23/11	Text	Text	2	Yes	This must have HD reported here. Indicates the beginning of the Header Record. Note: Every File must contain on HD record.
HD-RP	2	HD002	Payer	01/23/11	Integer	########	8	Yes	This is the Carriers ORG ID. This must match the Submitters ORG ID.
HD-RP	3	HD003	National Plan ID	01/23/11	Text		30	No	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.
HD-RP	4	HD004	Type of File	01/23/11	Integer	####	4	Yes	This must have 116 reported here. This is an indicator that defines the type of file and the data contained within the file.
HD-RP	5	HD005	Period Beginning Date	01/23/11	Date Period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the start date period of the reported period in the submission file.
HD-RP	6	HD006	Period Ending Date	01/23/11	Date Period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the end date period of the reported period in the submission file; if the period reported is a single month of the same year then Period Begin Date and Period End Date will be the same date.
HD-RP	7	HD007	Hospital Inpatient Record Count	01/23/11	Integer	#	10	Yes	Record Count for Relative Pricing for Hospital Inpatient
HD-RP	8	HD008	Hospital Outpatient Service Lookup	01/23/11	Integer	#	10	Yes	Record Count for Hospital Outpatient Service Lookups

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
			Count						
HD-RP	9	HD009	Hospital Outpatient Record Count	01/23/11	Integer	#	10	Yes	Record Count for Relative Pricing for Hospital Outpatient
HD-RP	10	HD010	Provider Service Lookup Count	01/23/11	Integer	#	10	Yes	Record Count for Provider Service Lookups
HD-RP	11	HD011	Provider Record Count	01/23/11	Integer	#	10	Yes	Record Count for Relative Pricing for Provider
HD-RP	12	HD012	RP Comments	01/23/11	Text	Text	500	No	Use this field to provide any additional information or to describe any data caveats for the Relative Price data submission.
HD-RP	13	HD013	Additional Comments	02/17/11	Text	Text	500	No	Payers may use this field to provide any additional information or comments regarding the submissions.
HD-RP	14	HD014	DRG Grouper Type	01/23/11	Text	Text	80	Yes	The diagnostic related group (DRG) grouper tool, software, or product used to calculate the average case-mix score in the hospital inpatient Relative Price files.
HD-RP	15	HD015	DRG Grouper Version	01/23/11	Text	Text	20	Yes	The grouper version number of the DRG grouper used to calculate the average case-mix score for the hospital inpatient Relative Price files.
HD-RP	16	HD016	File Type	04/12/11	Text	Text	3	Yes	Type of RP File HOS = Hospital PG = Physician Group OP = Other Provider If HD016="PG" then every (PGS003

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									/ PGS004 / PGS005 / PGS006 / PGS007) combination must equal 1.0 If HD 016="OP" then every (PGS003/PGS004/PGS005/PGS006/PGS007/ServiceGroupType) must equal 1.0.
HD-RP	17	HD017	Submission Type	01/23/11	Text	Flag	1	Yes	Type of Submission file T= Test P = Production
SL	1	SL001	Lookup Record Identifier	01/23/11	Text	Text	2	Yes	This must have a SL reported here. Indicates the beginning of the Service Lookup record. Note: 1. The Service Group Lookup Records must be in the beginning of the File. 2. There Must be one set of lookup records per Type (as stated in SL002)
SL	2	SL002	Type	01/23/11	Integer	#	1	Yes	Service Group Lookup Type **See Table F** (Organization Type)
SL	3	SL003	ID	01/23/11	Integer	#	3	Yes	Service Lookup Unique Identifier
SL	4	SL004	Code	01/23/11	Text	Free Text	15	Yes	A unique short code assigned to the service lookup
SL	5	SL005	Description	01/23/11	Text	Free Text	40	Yes	A unique description describing the service lookup
IPR	1	IPR001	Relative Pricing Record Type ID	01/23/11	Text	Text	3	Yes	This must have an IPR reported here. Indicates the beginning of the Hospital Inpatient Relative Pricing

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									record.
IPR	2	IPR002	Hospital Org ID	01/23/11	Integer	######	6	Yes	The ORGID assigned by the Center for the provider. Refer to Appendix A for the number associated with each provider Must be a CHIA-issued OrgID.
IPR	3	IPR003	Hospital Type Code	02/17/11	Integer	#	1	Yes	Hospital Type **See Table D** (Hospital Type)
IPR	4	IPR004	Insurance Category Code	01/22/11	Integer	#	1	Yes	Insurance Category **See Table B** (Insurance Category)
IPR	5	IPR005	Product Type Code	01/23/11	Integer	#	1	Yes	Product Type **See Table C** (Product Type)
IPR	6	IPR006	Discharges	01/23/11	Integer	########	9	Yes	Total Number of Discharges No negative values.
IPR	7	IPR007	Base Rate Indicator	02/17/11	Integer	#	1	Yes	Payment-Derived Base Rate Indicator. **See Table E** (Base Rate and Service Multiplier Indicator)
IPR	8	IPR008	Hospital Base Rate	01/23/11	Money	#######.##	12	Yes	Hospital Base Rate (see 4(a) of the data specification manual for further explanation) No negative values.
IPR	9	IPR009	Network Avg. Base Rate	04/30/12	Money	#######.##	12	No	Network Average Base Rate. The simple average of the hospital inpatient base rates for the relevant hospital category, by insurance category and by product type
IPR	10	IPR010	Total Non	01/23/11	Money	#######.##	12	Yes	The sum of all Non-Claims Related

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
			Claim Payments						Payments. See section 4 of the data specification manual for further explanation.
IPR	11	IPR011	Total Payments	01/23/11	Money	#######.##	12	Yes	The sum of all Claims Related Payments No negative values.
IPR	12	IPR012	Case Mix Score	01/23/11	Number	##.##	5	Yes	Case Mix Index for all cases Value must be positive, and between '.2' and '10'. NOTE: If case mix adjustment is not done for a given hospital type, then a 1 should be used for all case mix scores and situation should be noted in HD012 or HD013.
IPP	1	IPP001	Relative Pricing Record Type ID	01/23/11	Text	Text	3	Yes	This must have an IPP reported here. Indicates the beginning of the Hospital Inpatient Relative Pricing Product Mix record.
IPP	2	IPP002	IPP Record type	04/30/12	Integer	#	1	No	Hospital Inpatient Product Mix Record Type 1 = Hospital 2 = Carrier average If IPP002 is left blank, then it is assumed that the payer will not submit a carrier average
IPP	3	IPP003	Hospital Org ID	04/30/12	Integer	######	6	Yes	The ORGID assigned by the Center for the provider. Refer to Appendix A and the Center's website for the number associated with each

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									provider. Must be a CHIA-issued OrgID. Note: if IPP002 = 2 then IPP003 = 0.
IPP	4	IPP004	Hospital Type Code	02/17/11	Integer	#	1	Yes	Hospital Type **See Table D** (Hospital Type)
IPP	5	IPP005	Insurance Category Code	01/23/11	Integer	#	1	Yes	Insurance Category **See Table B** (Insurance Category)
IPP	6	IPP006	Product Type Code	01/23/11	Integer	#	1	Yes	Product Type **See Table C** (Product Type)
IPP	7	IPP007	Product Mix Ratio	01/23/11	Number	##.###	6	Yes	Product Mix Ratio for every (IPP003 / IPP004 / IPP005 / IPP006) combination. Every (IPP003 / IPP004 / IPP005) combination must equal 1.0.
HOM	1	HOM001	Relative Pricing Record Type ID	01/23/11	Text	Text	3	Yes	This must have a HOM reported here. Indicates the beginning of the Hospital Outpatient Relative Pricing Multiplier record.
HOM	2	HOM002	HOM Record type	05/31/12	Integer	#	1	Yes	Hospital Outpatient Multiplier Record Type 1 = Multiplier Service Group 2 = Total Claims Payments 3 = Total Non-Claims Payments Note: 1. There must be a corresponding (HOM002 =

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									1) for every supplied Outpatient Service group Lookup Record 2. There must be one (HOM002 = 2) for every (HOM003 / HOM004 / HOM005 /HOM006) combination 3. There must be one (HOM002 = 3) for every (HOM003 / HOM004 / HOM005 / HOM006) combination
HOM	3	HOM003	Hospital Org ID	01/23/11	Integer	######	6	Yes	The ORGID assigned by the Center for the provider. Refer to Appendix A and the Center's website for the number associated with each provider. Must be a CHIA-issued OrgID.
HOM	4	HOM004	Hospital Type Code	02/17/11	Integer	#	1	Yes	Hospital Type **See Table D** (Hospital Type)
HOM	5	HOM005	Insurance Category Code	01/23/11	Integer	#	1	Yes	Insurance Category **See Table B** (Insurance Category)
HOM	6	HOM006	Product Type Code	01/23/11	Integer	#	1	Yes	Product Type **See Table C** (Product Type)
HOM	7	HOM007	Service Lookup ID	01/23/11	Integer	###	3	Yes	Associated Service Group Lookup ID being reported on. Corresponds to SL003 Note: If HOM002 = 2 or 3, then HOM007 = 0.

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
HOM	8	HOM008	Service Multiplier Indicator	02/25/11	Integer	ID	1	Yes	Payment Derived Service Multiplier Indicator. For every (HOM003 / HOM004 / HOM005 / HOM006 / HOM007) combination there can only be one HOM008 value (1 or 2). **See Table E** (Base Rate and Service Multiplier Indicator) When HOM002 = 2 or 3, then HOM008 = 0.
HOM	9	HOM009	Multiplier	01/23/11	Number	#.##	4	Yes	Multiplier for every (HOM003 / HOM004 / HOM005 / HOM006 / HOM007) combination. Note: If HOM002 = 2 or 3, then HOM009 = 0. See section 4(b) of the data specification manual for further explanation. Multiplier value must fall in range: '0.1'-'20' Flag field if it falls between '10'-'20'
HOM	10	HOM010	Total Payments	01/23/11	Money	#######.##	12	Yes	The sum of all Claims or Non-Claims Related Payments for every (HOM003 / HOM004 / HOM005 / HOM006) combination. If HOM002 = 2, then no negative values. Note: If HOM002 = 1 then HOM010

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									= 0.
HOS	1	HOS001	Relative Pricing Record Type ID	01/23/11	Text	Text	3	Yes	This must have a HOS reported here. Indicates the beginning of the Hospital Outpatient Relative Pricing Service Mix record.
HOS	2	HOS002	HOS Record type	04/30/12	Integer	#	1	No	Hospital Outpatient Service Mix Record Type 1 = Hospital Specific 2 = Service Network Average If HOS002 is left blank, then it is assumed that the payer will not submit a service network average
HOS	3	HOS003	Hospital Org ID	04/30/12	Integer	######	6	Yes	The ORGID assigned by the Center for the provider. Refer to Appendix A and the Center's website for the number associated with each provider. Must be a CHIA-issued OrgID. Note: if HOS002 = 2 then HOS003 = 0.
HOS	4	HOS004	Hospital Type Code	02/17/11	Integer	#	1	Yes	Hospital Type **See Table D** (Hospital Type)
HOS	5	HOS005	Insurance Category Code	01/23/11	Integer	#	1	Yes	Insurance Category **See Table B** (Insurance Category)
HOS	6	HOS006	Product Type Code	01/23/11	Integer	#	1	Yes	Product Type **See Table C** (Product Type)
HOS	7	HOS007	Service	01/23/11	Integer	###	3	Yes	Associate Service Group Lookup ID

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
			Lookup ID						being reported on
HOS	8	HOS008	Service Multiplier indicator	04/30/12	Integer	ID	1	No	Payment Derived Service Multiplier Indicator. **See Table E** (Base Rate and Service Multiplier Indicator)
HOS	9	HOS009	Service Mix	01/23/11	Number	#.###	5	Yes	There must be one value service mix for every (HOS003 / HOS004 / HOS005 / HOS006 / HOS007) combination. Every (HOS003 / HOS004 / HOS005 / HOS006) combination must equal 1.0 See section 4 of the data specification manual for further explanation.
HOP	1	HOP001	Relative Pricing Record Type ID	01/23/11	Text	Text	3	Yes	This must have a HOP reported here. Indicates the beginning of the Hospital Outpatient Relative Pricing Product Mix record.
HOP	2	HOP002	HOP Record type	04/30/12	Integer	#	1	No	Hospital Outpatient Product Mix Record Type 1 = Hospital 2 = Carrier average If HOP002 is left blank, then it is assumed that the payer will not submit a carrier average
HOP	3	HOP003	Hospital Org ID	04/30/12	Integer	######	6	Yes	The ORGID assigned by the Center for the provider. Refer to Appendix A and the Center's website for the

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									number associated with each provider. Must be a CHIA-issued OrgID. Note: if HOS002 = 2 then HOS003 = 0.
HOP	4	HOP004	Hospital Type Code	02/17/11	Integer	#	1	Yes	Hospital Type **See Table D** (Hospital Type)
HOP	5	HOP005	Insurance Category Code	01/23/11	Integer	#	1	Yes	Insurance Category **See Table B** (Insurance Category)
HOP	6	HOP006	Product Type Code	01/23/11	Integer	#	1	Yes	Product Type **See Table C** (Product Type)
HOP	7	HOP007	Product Mix Ratio	01/23/11	Number	##.###	6	Yes	There must be one value product mix ratio for every (HOP003 / HOP004 / HOP005 / HOP006) combination. Every (HOP003 / HOP004 / HOP005) combination must equal 1.0. See section 4 of the data specification manual for further explanation.
PGM	1	PGM001	Relative Pricing Record Type ID	01/23/11	Text	Text	3	Yes	This must have a PGM reported here. Indicates the beginning of the Provider Relative Pricing Multiplier record.
PGM	2	PGM002	PGM Record type	05/31/12	Integer	#	1	Yes	Provider Multiplier Record Type

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									1 = Multiplier Service Group 2 = Total Claims Payments 3 = Total Non-Claims Payments Note: 1. There must be a corresponding (PGM002 = 1) for every supplied Service Lookup Record 2. There must be one (PGM002 = 2) for every (PGM003 / PGM004/ PGM005/ PGM006/ PGM007) combination. 3. There must be one (PGM002 = 3) for every (PGM003 / PGM004 / PGM005 / PGM006 / PGM007) combination.
PGM	3	PGM003	Provider Org ID	01/23/11	Integer	######	6	Yes	Provider Org ID. Must be a CHIA-issued OrgID. For aggregation of sites below threshold use: 999998 = Physician Groups, Non-Fee Schedule 999999 = Physician Groups, Fee Schedule 999901 = Ambulatory Surgical Centers 999902 = Community Health Centers 999903 = Community Mental Health Centers 999904 = Freestanding Clinical Labs 999905 = Freestanding Diagnostic

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									Imaging 999906 = Home Health Agencies 999907 = Skilled Nursing Facilities
PGM	4	PGM004	Provider Local Practice Group ID	01/23/11	Integer	######	6	Yes	Provider Local Practice Group Org ID. If PGM003 = an aggregate ORGID from above, then PGM004 = the same aggregate ORGID. Must be a CHIA-issued OrgID. For aggregation of sites below threshold use: 999998 = Physician Groups, Non-Fee Schedule 999999 = Physician Groups, Fee Schedule 999901 = Ambulatory Surgical Centers 999902 = Community Health Centers 999903 = Community Mental Health Centers 999904 = Freestanding Clinical Labs 999905 = Freestanding Diagnostic Imaging 999906 = Home Health Agencies 999907 = Skilled Nursing Facilities
PGM	5	PGM005	Pediatric Indicator	02/25/11	Integer	ID	1	Yes	Pediatric Indicator. 0 = Less than 75% of the provider's patients are children age 18 and under 1 = 75% or more of the provider's patients are children age 18 and under

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									Value must be either a '0' or '1'.
PGM	6	PGM006	Insurance Category Code	01/23/11	Integer	#	1	Yes	Insurance Category **See Table B** (Insurance Category)
PGM	7	PGM007	Product Type Code	01/23/11	Integer	#	1	Yes	Product Type **See Table C** (Product Type)
PGM	8	PGM008	Service Lookup ID	01/23/11	Integer	ID	3	Yes	Associate Service Group Lookup ID being reported. Note: If PGM002 = 2 or 3, then PGM008 = 0.
PGM	9	PGM009	Service Multiplier Indicator	02/25/11	Integer	ID	1	Yes	Payment Derived Service Multiplier Indicator. For every (PGM003 / PGM004 / PGM005 / PGM006 / PGM007 / PGM008) combination there can only be one PGM009 value (1 or 2). **See Table E** (Base Rate and Service Multiplier Indicator) When PGM002 = 2 or 3, then PGM009 = 0.
PGM	10	PGM010	Multiplier	01/23/11	Money	#######.##	12	Yes	Multiplier for every (PGM003 / PGM004 / PGM005 / PGM006 / PGM007 / PGM008) combination. See section 4(b) of the data specification manual for further explanation. Note: If PGM002 = 2 or 3 then

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									PGM010 = 0. Multiplier value must fall in range: '0.1'-'20' Flag field if it falls between '10'-'20'
PGM	11	PGM011	Total Payments	02/18/11	Money	#######.##	12	Yes	The sum of all Claims or Non-Claims Related Payments for every (PGM003 / PGM004 / PGM005 / PGM006 / PGM007) combination. If PGM002 = 2, then no negative values. Note: If PGM002 = 1 then PGM011 = 0.
PGS	1	PGS001	Relative Pricing Record Type ID	01/23/11	Text	Text	3	Yes	This must have a PGS reported here. Indicates the beginning of the Provider Relative Pricing Service Mix record.
PGS	2	PGS002	PGS Record type	04/30/12	Integer	#	1	No	Provider Service Mix Record Type 1 = Service Group 2 = Service Network Average If PGS002 is left blank, then it is assumed that the payer will not submit service network averages
PGS	3	PGS003	Provider Org ID	04/30/12	Integer	######	6	Yes	Provider Org ID. Must be a CHIA-issued OrgID. For aggregation of sites below threshold use: 999998 = Physician Groups, Non-

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									Fee Schedule
									999999 = Physician Groups, Fee Schedule
									999901 = Ambulatory Surgical Centers
									999902 = Community Health Centers
									999903 = Community Mental Health Centers
									999904 = Freestanding Clinical Labs
									999905 = Freestanding Diagnostic Imaging
									999906 = Home Health Agencies
									999907 = Skilled Nursing Facilities
									For Service Network Averages use: If PGS002 = 2 and HD016 = "PG", then PGS003 = 0.
									If PGS002 = 2 and HD016 = "OP", then use the following codes:
									999100 = Nt. Avg. Ambulatory Surgical Centers
									999200 = Nt. Avg. Community Health Centers
									999300 = Nt. Avg. Community Mental Health Centers
									999400 = Nt. Avg. Freestanding Clinical Labs
									999500 = Nt. Avg. Freestanding Diagnostic Imaging
									999600 = Nt. Avg. Home Health Agencies
									999700 = Nt. Avg. Skilled Nursing Facilities

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
PGS	4	PGS004	Provider Local Practice Group Org ID	04/30/12	Integer	######	6	Yes	Provider Local Practice Group Org ID. Must be a CHIA-issued OrgID. If PGS003 = an aggregate ORGID from above, then PGS004 = the same aggregate ORGID. For aggregation of sites below threshold use: 999998 = Physician Groups, Non-Fee Schedule 999999 = Physician Groups, Fee Schedule 999901 = Ambulatory Surgical Centers 999902 = Community Health Centers 999903 = Community Mental Health Centers 999904 = Freestanding Clinical Labs 999905 = Freestanding Diagnostic Imaging 999906 = Home Health Agencies 999907 = Skilled Nursing Facilities For Service Network Averages use: If PGS002 = 2 and HD016 = "PG", then PGS004 = 0. If PGS002 = 2 and HD016 = "OP", then use the following codes: 999100 = Nt. Avg. Ambulatory Surgical Centers

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									999200 = Nt. Avg. Community Health Centers 999300 = Nt. Avg. Community Mental Health Centers 999400 = Nt. Avg. Freestanding Clinical Labs 999500 = Nt. Avg. Freestanding Diagnostic Imaging 999600 = Nt. Avg. Home Health Agencies 999700 = Nt. Avg. Skilled Nursing Facilities
PGS	5	PGS005	Pediatric Indicator	02/25/11	Integer	ID	1	Yes	Pediatric Indicator. 0 = Less than 75% of the provider's patients are children age 18 and under 1 = 75% or more of the provider's patients are children age 18 and under Value must be either a '0' or '1'.
PGS	6	PGS006	Insurance Category Code	01/23/11	Integer	#	1	Yes	Insurance Category **See Table B** (Insurance Category)
PGS	7	PGS007	Product Type Code	01/23/11	Integer	#	1	Yes	Product Type **See Table C** (Product Type)
PGS	8	PGS008	Service Lookup ID	01/23/11	Integer	###	3	Yes	Associated Service Group Lookup ID being reported on
PGS	9	PGS009	Service Multiplier Indicator	04/30/12	Integer	ID	1	No	Payment Derived Service Multiplier Indicator. **See Table E** (Base Rate and Service Multiplier Indicator)

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
PGS	10	PGS010	Service Mix	01/23/11	Number	#.###	5	Yes	There must be one value service mix for every (PGS003 / PGS004 / PGS005 / PGS006 / PGS007 / PGS008) combination. If HD016 = "PG", then every (PGS003 / PGS004 / PGS005 / PGS006 / PGS007) combination must equal 1.0. If HD016 = "OP", then every (PGS003/PGS004/PGS005/PGS006/PGS007/ServiceGroupType) must equal 1.0. [NOTE: ServiceGroupLookupType is SL002] See section 4(b) of the data specification manual for further explanation.
PGP	1	PGP001	Relative Pricing Record Type ID	01/23/11	Text	Text	3	Yes	This must have a PGP reported here. Indicates the beginning of the Provider Relative Pricing Product Mix record.
PGP	2	PGP002	PGP Record type	04/30/12	Integer	#	1	No	Provider Product Mix Record Type 1 = Provider Specific 2 = Network Average If PGP002 is left blank, then it is assumed that the payer will not submit network averages
PGP	3	PGP003	Provider Org	04/30/12	Integer	######	6	Yes	Provider Org ID.

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
			ID						Must be a CHIA-issued OrgID. For aggregation of sites below threshold use: 999998 = Physician Groups, Non-Fee Schedule 999999 = Physician Groups, Fee Schedule 999901 = Ambulatory Surgical Centers 999902 = Community Health Centers 999903 = Community Mental Health Centers 999904 = Freestanding Clinical Labs 999905 = Freestanding Diagnostic Imaging 999906 = Home Health Agencies 999907 = Skilled Nursing Facilities For Network Averages use: If PGP002 = 2 and HD016 = "PG", then PGP003 = 0. If PGP002 = 2 and HD016 = "OP", then use the following codes: 999100 = Nt. Avg. Ambulatory Surgical Centers 999200 = Nt. Avg. Community Health Centers 999300 = Nt. Avg. Community Mental Health Centers 999400 = Nt. Avg. Freestanding

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									Clinical Labs 999500 = Nt. Avg. Freestanding Diagnostic Imaging 999600 = Nt. Avg. Home Health Agencies 999700 = Nt. Avg. Skilled Nursing Facilities
PGP	4	PGP004	Provider Local Practice Group ID	04/30/12	Integer	######	6	Yes	Provider Local Practice Group Org ID. Must be a CHIA-issued OrgID. If PGP003 = an aggregate ORGID from above, then PGP004 = the same aggregate ORGID. For aggregation of sites below threshold use: 999998 = Physician Groups, Non-Fee Schedule 999999 = Physician Groups, Fee Schedule 999901 = Ambulatory Surgical Centers 999902 = Community Health Centers 999903 = Community Mental Health Centers 999904 = Freestanding Clinical Labs 999905 = Freestanding Diagnostic Imaging 999906 = Home Health Agencies 999907 = Skilled Nursing Facilities For Network Averages use:

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									If PGP002 = 2 and HD016 = "PG", then PGP004 = 0. If PGP002 = 2 and HD016 = "OP", then use the following codes: 999100 = Nt. Avg. Ambulatory Surgical Centers 999200 = Nt. Avg. Community Health Centers 999300 = Nt. Avg. Community Mental Health Centers 999400 = Nt. Avg. Freestanding Clinical Labs 999500 = Nt. Avg. Freestanding Diagnostic Imaging 999600 = Nt. Avg. Home Health Agencies 999700 = Nt. Avg. Skilled Nursing Facilities
PGP	5	PGP005	Pediatric Indicator	02/25/11	Integer	ID	1	Yes	Pediatric Indicator. 0 = Less than 75% of the provider's patients are children age 18 and under 1 = 75% or more of the provider's patients are children age 18 and under Value must be either '0' or '1'.
PGP	6	PGP006	Insurance Category Code	01/23/11	Integer	#	1	Yes	Insurance Category **See Table B** (Insurance Category)
PGP	7	PGP007	Product Type Code	01/23/11	Integer	#	1	Yes	Product Type **See Table C** (Product Type)
PGP	8	PGP008	Product Mix Ratio	01/23/11	Number	##.###	6	Yes	There must be one value product

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									mix ratio for every (PGP003 / PGP004 / PGP005 / PGP006 / PGP007) combination. Every (PGP003 / PGP004 / PGP005 / PGP006) combination must equal 1.0. See section 4(b) of the data specification manual for further explanation.

Table B: Insurance Category

ID	Description
1	Medicare Advantage
2	Medicaid
3	Commonwealth Care
4	Commercial (self and fully insured)
5	Medicare and Medicaid Dual-Eligibles, 65 and over
6	Medicare and Medicaid Dual-Eligibles, 18-64
7	Other

Table C: Product Type

ID	Description
1	HMO and POS
2	PPO
3	Indemnity
4	Other

Table D: Hospital Type

ID	Description
1	Acute Hospital
2	Psychiatric or Substance Abuse Hospital or Acute Hospital Behavioral Health only
3	Chronic Hospital
4	Rehabilitation Hospital

Table E: Base Rate and Service Multiplier Indicator

ID	Description
1	Negotiated base rate or multiplier (not calculated)
2	Calculated payment-derived base rate or multiplier
3	Standard per unit rate (use for hospital inpatient only – non-acute hospitals or acute hospitals with waiver)

Table F: Organization Type

ID	Description
1	Hospital
2	Physician Group
3	Ambulatory Surgical Center
4	Community Health Center
5	Community Mental Health Center
6	Freestanding Clinical Labs
7	Freestanding Diagnostic Imaging
8	Home Health Agencies
9	Skilled Nursing Facilities

Table G: File Record Legend

File Field	Description
HD-RP	Relative Pricing header record
SL	Service Group Lookup record
IPR	Hospital Inpatient Relative Pricing record
IPP	Hospital Inpatient Relative Pricing Product Mix record
HOM	Hospital Outpatient Relative Pricing Multiplier record
HOS	Hospital Outpatient Relative Pricing Service Mix record
HOP	Hospital Outpatient Relative Pricing Product Mix record
PGM	Provider with ORGID Relative Pricing Multiplier record
PGS	Provider with ORGID Relative Pricing Service Mix record
PGP	Provider with ORGID Relative Pricing Product Mix record

File Submission Naming Conventions

Relative Price data submissions should follow the following naming conventions:

SubmissionType_[SubType]_YYYY_[Version].dat,

Submission Type is **REL288** Relative Prices data submissions

SubType is <u>required and only valid</u> for Relative Pricing to distinguish hospital and non-hospital provider submission files.
      HOS – Hospital relative price file
      PG – Physician Group relative price file
      OP – Other Provider (non-hospital, non-physician group) relative price file

YYYY is the four digit reporting year

Version is <u>optional</u>, and may be used to distinguish multiple versions of a submission

The file extension must be .dat

The name is not case sensitive.

Below are examples of validly named files:

- REL288_HOS_2010_1.dat or rel288_hos_2010_01.dat or rel288_hos_2010.dat

- REL288_PG_2010_1.dat or rel288_pg__2010_01.dat or rel288_pg__2010.dat

- REL288_OP_2010_1.dat or rel288_op_2010_01.dat or rel288_op_2010.dat